STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175146	A. BUILDING _____ B. WING _____	03/20/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUTCHINSON REGIONAL MEDICAL CENTER INC (SNU)	1701 E 23RD AVE HUTCHINSON, KS 67502

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following citations represent the findings of Health Resurvey #GL8D11	F 000		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: The facility census totaled 12 residents. All 12 residents were sampled for care plans. Based on interview, and record review, the facility failed to develop care plan interventions related to weight loss for one resident (closed record) with severe weight loss.(#24) Findings included:	F 279		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175146	A. BUILDING _____ B. WING _____	03/20/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUTCHINSON REGIONAL MEDICAL CENTER INC (SNU)	1701 E 23RD AVE HUTCHINSON, KS 67502

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 1	F 279		

- Review of resident #24's admission orders dated 10/12/12 revealed the resident had a diagnosis of diabetes and medication list including Novolog insulin per sliding scale at a low correction dose.

Review of the admission MDS (minimum data set) for resident #24 dated 10/19/12 revealed the resident had a BIMS (brief interview for mental status) score of 10/15 which indicated moderate cognitive impairment. The MDS also revealed the resident was independent with eating.

Review of the CAA (care area assessment) dated 10/19/12 revealed the Nutrition CAA stated: the resident had poor nutritional intake and although the resident can feed his/her self and family brings food from home, intake is only 0-25% of most meals.

Further review of the CAAs, dated 10/19/12, revealed the Cognitive loss/Dementia CAA stated the resident had short term memory loss and will need assist with appropriate choices. The ADL function CAA stated the resident had a decline in his/her ability to care for his/her self and needed assist to regain self care abilities so he/she can return home alone.

Review of the care plan dated 10/12/12 revealed no interventions for nutrition or weight loss in the care plan, verified by administrative nurse A on 3/14/13 at 1:25 P.M..

The medical record lacked evidence of any interventions added to address the continued weight loss. This was confirmed by both

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175146	A. BUILDING _____ B. WING _____	03/20/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUTCHINSON REGIONAL MEDICAL CENTER INC (SNU)	1701 E 23RD AVE HUTCHINSON, KS 67502

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 2	F 279		

administrative nurse A on 3/14/13 at 1:25 P.M. and administrative dietary staff F on 3/19/13 at 10:15 A.M.

Review of lab reports revealed the following results with acceptable ranges in parenthesis:

10/14/12: Albumin- 2.4 (3.4-5.0) Total Protein- 6.9 (6.4-8.2)

10/19/12: Albumin- 1.9 (3.4-5.0) Total Protein- 5.7 (6.4-8.2)

Review of weights revealed the following weights obtained:

10/12/12- 70.9kg (156.0 lbs)

10/14/12- 70.2kg (154.4 lbs)

10/19/12- 69.0kg (151.8 lbs)

10/26/12- 67.1kg (148 lbs)

The weight loss between 10/12/12 and 10/26/12 totaled 8.0 lbs or 5.1% weight loss in 14 days.

Review of the Nutritional assesments between 10/12/12 and 10/26/12 in the medical record revealed the resident's meal intake was 0-25% for the majority of meals (some were over 25% and some were 0%) during resident's stay in the facility.

During an interview on 3/14/13 at 1:25 P.M., administrative nurse A confirmed a definite weight loss. Staff A also confirmed that a care plan was not initiated for nutrition or weight loss for this

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175146	A. BUILDING _____ B. WING _____	03/20/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUTCHINSON REGIONAL MEDICAL CENTER INC (SNU)	1701 E 23RD AVE HUTCHINSON, KS 67502

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 3 resident, he/she stated there was a definite weight loss and it should have been care planned. Although staff identified poor nutritional intake on the CAA dated 10/19/12, they failed to address poor nutritional intake as a problem on the care plan. During an interview on 3/18/13 at 8:20 A.M., nursing staff B stated care plan meetings are held every Tuesday morning and attendees included the medical director, a representative from therapy, a dietician, social services, and the resident and/or family may attend. The facility failed to establish a plan of care to address a severe weight loss for resident #24.	F 279		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after	F 280		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175146	A. BUILDING _____ B. WING _____	03/20/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUTCHINSON REGIONAL MEDICAL CENTER INC (SNU)	1701 E 23RD AVE HUTCHINSON, KS 67502

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 4 each assessment. This REQUIREMENT is not met as evidenced by: 280 D The facility census totaled 12 residents of which 2 family interviews were conducted. The family interviews revealed that 1 resident family was not notified to attend the resident's care plan meeting. Based on observation, record review , and confidential interview, the facility failed to notify a resident's family of the resident's care plan meeting. Findings included: - Resident not identified to maintain confidentiality of family interview. Review of the admission MDS (minimum data set) dated 3/2/13 revealed the resident had a BIMS (Brief Interview for Mental Status) score of 15/15 which indicated no cognitive impairment. The resident required total assist of 1 staff for locomotion on/off unit, total assist of 2 staff for bed mobility, transfers, toileting, and personal hygiene, and extensive assist of 2 for dressing. Review of the CAA (Care Area Assessment) dated 3/2/13 revealed the resident had increased dependence for safe and completeness of ADLs (Activities of Daily Living) because of weakness from pneumonia. The resident also had a potential for altered nutrition related to lactose	F 280		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175146	A. BUILDING _____ B. WING _____	03/20/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUTCHINSON REGIONAL MEDICAL CENTER INC (SNU)	1701 E 23RD AVE HUTCHINSON, KS 67502

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 5	F 280		

intolerance, end stage renal disease, and was unwilling to accept supplements or eat more than 3 times per day. Furthermore, the CAA identified the resident had a pressure ulcer on admission and the resident had a history of immobility.

Observation of resident on 3/14/13 at 8:25 A.M. revealed the resident was sitting up in bed. The resident was alert and oriented and stated he/she would be leaving on this day hoping to go to a particular nursing facility.

During a confidential interview on 3/12/13 at 11:00 A.M., the resident's family member stated he/she was not invited to the resident's care plan meeting. He/she stated the facility called him/her a day or so after the meeting. He/she also stated he/she had telephone discussions with social services regarding discharge plans for the resident.

During an interview on 3/18/13 at 8:30 A.M., nursing staff G reported residents and family are notified of the care plan meeting schedule when they are admitted to the unit. He/she stated the RN (Registered Nurse) who completed the initial assessment would inform the resident and family of the care plan meetings. RNs have to do the initial assessments.

During an interview on 3/18/13 at 8:15 A.M. Nursing staff H stated he/she did not work the unit very often so he/she did not know how care plan meetings were scheduled.

During an interview on 3/18/13 at 8:20 A.M. administrative nursing staff B reported care plan meetings were held on Tuesday mornings on the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175146	A. BUILDING _____ B. WING _____	03/20/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUTCHINSON REGIONAL MEDICAL CENTER INC (SNU)	1701 E 23RD AVE HUTCHINSON, KS 67502

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 6	F 280		

unit and the medical director, a therapy representative, the dietician, social services, and the resident and/or family may attend. Staff B stated a book located at the nurses desk was for family and resident to sign if they planned to attend a care plan meeting. He/she also stated pink notifications (with care plan meeting date and time) were posted on a bulletin board in the hall by the nurses station. Staff B further stated the nurses informed residents and/or family about the book to sign up for scheduled care plan meetings. Staff B reported the social worker and/or staff B would meet with the family or resident if a care plan meeting was missed. Staff B verified no documentation was available that indicated the resident's family was notified of the care plan meeting.

During an interview conducted on 3/18/13 at 8:45 A.M., administrative nursing staff A stated care plan meetings were scheduled every Tuesday morning at 9:00 A.M. and family & residents were invited to attend. Staff A had to call administrative nursing staff B to find out how residents and family members were invited to care plan meetings. Staff A then stated he/she would add a notification of care plan meeting form in the admission packet to ensure proper notification of care plan meetings.

Review of the facility's policy, Interdisciplinary Plan of Care, dated 12/12 stated the patient and family will be aware of the Plan of Care and be able to verbalize primary goals/outcomes.

The facility failed to notify a resident's family of the resident's care plan meeting. The resident's family member had no input into the resident's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175146	A. BUILDING _____ B. WING _____	03/20/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUTCHINSON REGIONAL MEDICAL CENTER INC (SNU)	1701 E 23RD AVE HUTCHINSON, KS 67502

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 7 care plan.	F 280		
F 325 SS=G	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: 325 G The facility census totaled 12 residents. Three residents were sampled for nutrition. Based on interview, and record review, the facility failed to identify and provide intervention for one resident (closed record) with severe weight loss of 5.1% in a 14 day time span.(#24) Findings included: - Review of the admission MDS (minimum data set) for resident #24 dated 10/19/12 revealed the resident (admitted 10/12/12) had a BIMS (brief interview for mental status) score of 10/15 which indicated moderate cognitive impairment. The MDS also revealed the resident was independent with eating.	F 325		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175146	A. BUILDING _____ B. WING _____	03/20/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUTCHINSON REGIONAL MEDICAL CENTER INC (SNU)	1701 E 23RD AVE HUTCHINSON, KS 67502

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 325	Continued From page 8	F 325		

Review of the CAA (care area assessment) dated 10/19/12 revealed the Nutrition CAA stated: the resident had poor nutritional intake and although the resident can feed his/her self and family brings food from home, intake is only 0-25% of most meals.

Further review of the CAAs, dated 10/19/12, revealed the Cognitive loss/Dementia CAA stated the resident had short term memory loss and will need assist with appropriate choices. The ADL function CAA stated the resident had a decline in his/her ability to care for his/her self and needed assist to regain self care abilities so he/she can return home alone.

Review of the care plan dated 10/12/12 revealed no interventions for nutrition or weight loss in the care plan, verified by administrative nurse A on 3/14/13 at 1:25 P.M.

Medical record review revealed a dietician's note dated 10/16/12 recommended an appetite stimulant because the resident's oral intake and appetite were poor.

Medical record review also revealed a dietician's note dated 10/18/12 recommended adding Glucerna shakes 3 times a day with meals.

The medical record lacked evidence of any interventions added to address the continued weight loss. This was confirmed by both administrative nurse A on 3/14/13 at 1:25 P.M. and administrative dietary staff F on 3/19/13 at 10:15 A.M.

Review of lab reports revealed the following

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175146	A. BUILDING _____ B. WING _____	03/20/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUTCHINSON REGIONAL MEDICAL CENTER INC (SNU)	1701 E 23RD AVE HUTCHINSON, KS 67502

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 325	Continued From page 9 results with acceptable ranges in parenthesis: 10/14/12: Albumin- 2.4 (3.4-5.0) Total Protein- 6.9 (6.4-8.2) 10/19/12: Albumin- 1.9 (3.4-5.0) Total Protein- 5.7 (6.4-8.2) Review of weights revealed the following weights obtained: 10/12/12- 70.9kg (156.0 lbs) 10/14/12- 70.2kg (154.4 lbs) 10/19/12- 69.0kg (151.8 lbs) 10/26/12- 67.1kg (148 lbs) The weight loss between 10/12/12 and 10/26/12 totaled 8.0 lbs or 5.1% weight loss in 14 days. Review of the Nutritional assesments between 10/12/12 and 10/26/12 in the medical record revealed the resident's meal intake was 0-25% for the majority of meals (some were over 25% and some were 0%) during resident's stay in the facility. During an interview on 3/14/13 at 1:25 P.M., administrative nurse A confirmed a definite weight loss and after reviewing the dietary recommendations, administrative nurse A confirmed the appetite stimulant and Glucerna were not ordered as interventions for weight loss for this resident. During a telephone interview on 3/19/13 at 10:15	F 325		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175146	A. BUILDING _____ B. WING _____	03/20/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUTCHINSON REGIONAL MEDICAL CENTER INC (SNU)	1701 E 23RD AVE HUTCHINSON, KS 67502

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 325	Continued From page 10 A.M. administrative dietary staff F confirmed recommendation for Glucerna shakes TID with meals because the resident was not eating well. Staff F also confirmed that both recommendations for appetite stimulant dated 10/16/12 and Glucerna dated 10/18/12 were not ordered by the physician. During an interview on 3/18/13 at 8:20 A.M., nursing staff B stated care plan meetings are held every Tuesday morning and attendees include the medical director, a representative from therapy, a dietician, social services, and the resident and/or family may attend. Although professional staff met weekly to review and revise the resident's care plan, none of the staff identified the failure to carry out the dietitian's recommendations for an appetite stimulant and Glucerna three times a day. The facility failed to ensure a resident, with a severe weight loss of 5.1% of his/her body weight in a 14 day time span, received appropriate intervention to halt weight loss for this resident.	F 325		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a	F 329		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175146	A. BUILDING _____ B. WING _____	03/20/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUTCHINSON REGIONAL MEDICAL CENTER INC (SNU)	1701 E 23RD AVE HUTCHINSON, KS 67502

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 11 resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: The facility census totaled 12 residents with 10 residents sampled for unnecessary drug review. Based on observation, interview and record review the facility failed to ensure that 3 out of 10 sampled residents were free of unnecessary drugs in regards to monitoring black box warnings for serious adverse side effects. (#98, #100, and #107). Findings included: - Review of the physician order sheet for resident #98 dated 3/8/13 listed the following diagnoses: respiratory failure, hypertension (high blood pressure), multiple diabetic foot ulcers with infection, diabetes mellitus (high blood sugar), arthritis (inflammation of a joint) pleural effusion (abnormal accumulation of fluid in the lungs) and acute renal failure (inability of the kidneys to excrete wastes, concentrate urine and conserve electrolytes).	F 329		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175146	A. BUILDING _____ B. WING _____	03/20/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUTCHINSON REGIONAL MEDICAL CENTER INC (SNU)	1701 E 23RD AVE HUTCHINSON, KS 67502

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 12 The resident was admitted to the unit on 3/8/13 with no MDS (minimum data set)due at the time of survey The care plan failed to list specific warnings for medications with black box warnings (BBW). Review of the physician orders dated 3/8/13 revealed an order for the following medication with a BBW: (Medication) Tenormin 25 mg (milligram) tablet 1 once daily for hypertension. The 2011 Lexi-Comp Drug Information Handbook for Nursing, 16th Edition, page 123 identified a BBW for Tenormin of the medication should not be withdrawn abruptly to avoid tachycardia, hypertension, ischemia. Observation on 3/13/13 at 1:30 p.m. revealed the resident sat in recliner watching TV. The resident was talkative and in good spirits. The Resident had an intravenous line (IV) infusing with the help of a pump in the back of his/her left hand. During an interview on 3/13/13 at 3:30 p.m. licensed nurse D reported the black box warnings for the medications residents received were on the nurses ' electronic MAR. The resident had no mood or behavior problems. During an interview on 3/14/13 at 10:05 a.m. administrative nurse B was unaware the medications with black box warnings had to have specific warnings and adverse side effects related to that specific medication for black box	F 329		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175146	A. BUILDING _____ B. WING _____	03/20/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUTCHINSON REGIONAL MEDICAL CENTER INC (SNU)	1701 E 23RD AVE HUTCHINSON, KS 67502

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 13 warnings on the residents' care plan. During an interview on 3/14/13 at 7:30 a.m. Administrative A, reported he/she was not aware of the black box warnings, including specific adverse side effects needed to be on the care plans. During an interview on 3/18/13 at 12:15 p.m. Consultant E, reported that all medications with black box warnings had a pop up screen on the electronic MAR (medication administration record) each time the medication was given to alert the nurses of the black box warning and what they were to monitor for. During an interview on 3/14/13 at 7:30 a.m. Administrative nurse A reported that the unit had no policy regarding black box warnings. The facility failed to identify and monitor the resident for the adverse side effects associated with the administration of medications with black box warnings. - Review of the physicians history and physical for resident #100 dated 2/28/13 revealed the following diagnoses: methicillin resistant staphacoccus areas infection in knee, seizures (violent involuntary series of contractions of a group of muscles), atrial fibrillation (rapid irregular heart beat), depression (abnormal emotional state characterized by exaggerated feelings of sadness) and urge incontinence (involuntary passage of urine occurring after a strong sense of urgency to void). Review of the MDS (minimum data set) for	F 329		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175146	A. BUILDING _____ B. WING _____	03/20/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUTCHINSON REGIONAL MEDICAL CENTER INC (SNU)	1701 E 23RD AVE HUTCHINSON, KS 67502

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 14	F 329		

resident #100 dated 3/7/13 revealed the resident was cognitively intact with a BIMS (brief interview for mental status) score of 13. The resident had no mood or behavior problems. The resident was receiving antibiotics, and antipsychotic medication for agitation, had infection in total knee resulting in removal of the hardware and needed minimal assist of one with her daily care. The resident received skilled rehab (Physical Therapy, Occupational Therapy).

Review of the CAAs (care area assessment) dated 3/7/13 revealed:

Cognitive CAA- the resident had altered cognition/confusion at times and needed multidisciplinary care planning to assist the resident with making appropriate decisions regarding ADL (activities of daily living).

The care plan had BBW (black box warning) medications though lacked interventions for the monitoring specific side effects of black box warnings.

Review of the physician ' s admission order sheet instructed the nursing staff to give the following medications with a BBW:

(Medication) Sotalol 120 mg (milligram) BID (twice daily) for atrial fibrillation.

The 2011 Lexi-Comp Drug Information Handbook for Nursing, 16th Edition, page 1352 identified a BBW of initiation or dosage increases should be done in the hospital with continuous monitoring by staff familiar with recognizing and the treatment of life threatening arrhythmias.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175146	A. BUILDING _____ B. WING _____	03/20/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUTCHINSON REGIONAL MEDICAL CENTER INC (SNU)	1701 E 23RD AVE HUTCHINSON, KS 67502

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 15 (Medication) Xarelto 10mg by mouth daily for atrial fibrillation. Review of the website www.xareltohcp.com revealed a BBW for Xarelto for discontinuing Xarelto in patients with Atrial Fibrillation increased the risk of a stroke. Observation on 3/13/13 at 3:50 p.m. revealed the resident lying in bed in high fowler ' s position with the TV (television) on. A knee immobilizer was in place. The resident was relaxed and reading a book with no distress noted. During an interview on 3/13/13 the resident reported he/she felt good and did not have a lot of pain in her knee. The resident would like to go home but stated he/she had several surgeries lined up for her knee so thought he/she would be there for a while yet. The resident was calm and in good spirits. During an interview on 3/13/13 at 3:30 p.m. licensed nurse D reported the resident was alert and oriented and required assist of one with his/her daily care. This nurse had not seen any behaviors from the resident but stated a day last week the resident was so wild she required one on one supervision. During an interview on 3/14/13 at 10:05 a.m. administrative nurse B was unaware the medications with black box warnings had to have specific warnings and adverse side effects related to that specific medication for black box warnings.	F 329		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175146	A. BUILDING _____ B. WING _____	03/20/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUTCHINSON REGIONAL MEDICAL CENTER INC (SNU)	1701 E 23RD AVE HUTCHINSON, KS 67502

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 16	F 329		

During an interview on 3/14/13 at 7:30 a.m. Administrative nurse a reported he/she was not aware that black box warnings including specific adverse side effects needed to be on the care plans.

During an interview on 3/18/13 at 12:15 p.m. consultant E, reported that all medications with black box warnings had a pop up screen on the electronic MAR each time the medication was given to alert the nurses of the black box warning and what they were to monitor for.

During an interview on 3/14/13 at 7:30 a.m. Administrative nurse A reported that the unit had no policy regarding black box warnings

The facility failed to identify and monitor the resident for the adverse side effects associated with the administration of medications with black box warnings.

- Review of the physician admission notes for resident #107 dated 3/6/13 listed the following diagnoses: Metastatic lung cancer (cancer that has spread to other areas of the body), chronic obstructive pulmonary disease (long-term, progressive disease of the lungs that primarily caused a shortness of breath), right sided pneumonia (inflammation of the lung), right sided rib pain, anemia of chronic disease (a condition without enough healthy red blood cells to carry adequate oxygen to body tissues, constipation (difficulty passing stools), atrial fibrillation (irregular, fast heart beat) and hypertension (high blood pressure).

No MDS (minimum data set) had been completed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175146	A. BUILDING _____ B. WING _____	03/20/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUTCHINSON REGIONAL MEDICAL CENTER INC (SNU)	1701 E 23RD AVE HUTCHINSON, KS 67502

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 17 due to resident admitted on 3/6/13 and the assessment not due yet. Review of the care plan dated 3/6/13 listed Bumex, Toprol XL, MS Contin and Coumadin as having black box warnings with no specific side effects noted for each medication. Review of the physician orders dated 3/8/13 revealed orders for the following: (Medication) Lasix 20 mg (milligram) given by mouth daily. The 2011 Lexi-Comp Drug Information Handbook for Nursing, 16th Edition, page 649 identified a BBW for Lasix of if given in excessive amounts; furosemide can lead to profound diuresis, resulting in fluid and electrolyte imbalance. (Medication) Bumex 0.5 mg twice a day. The 2011 Lexi-Comp Drug Information Handbook for Nursing, 16th Edition, page 190 identified a BBW for Bumex of at risk for severe dehydration. (Medication) Toprol XL 100 mg by mouth daily. The 2011 Lexi-Comp Drug Information Handbook for Nursing, 16th Edition, page 934 identified a BBW for Toprol XL of the medication should not be withdrawn abruptly to prevent tachycardia, hypertension, or ischemia. (Medication) MS Contin 30 mg tablet by mouth twice a day. The 2011 Lexi-Comp Drug Information Handbook	F 329		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175146	A. BUILDING _____ B. WING _____	03/20/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUTCHINSON REGIONAL MEDICAL CENTER INC (SNU)	1701 E 23RD AVE HUTCHINSON, KS 67502

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 18 for Nursing, 16th Edition, page 969 identified a black box warning of medication may cause respiratory distress and central nervous system depression. (Medication) Coumadin 5 mg 1 tab by mouth daily. The 2011 Lexi-Comp Drug Information Handbook for Nursing, 16th Edition, page 1498 identified a black box warning of may cause fatal bleeding. Observation on 3/12/13 at 10:30 a.m. revealed the resident sat in a reclining chair in his/his room visiting with his/her spouse. The resident denied any discomfort to the licensed nurse when he/she entered the room. During an interview on 3/12/13 at 10:30 a.m. the resident stated he/she felt much better but still had a cough. He/she reported that he was going home that day and that Hospice was coming to visit the resident and spouse. The resident was anxious to get home. During an interview on 3/14/13 at 10:05 a.m. administrative nurse B was unaware the medications with black box warnings had to have specific warnings and adverse side effects related to that specific medication for black box warnings. During an interview on 3/14/13 at 7:30 a.m. Administrative nurse A reported he/she was not aware of the black box warnings including specific adverse side effects that needed to be on the care plans.	F 329		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175146	A. BUILDING _____ B. WING _____	03/20/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUTCHINSON REGIONAL MEDICAL CENTER INC (SNU)	1701 E 23RD AVE HUTCHINSON, KS 67502

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 19 During an interview on 3/18/13 at 12:15 p.m. consultant E reported that all medications with black box warnings had a pop up screen on the electronic MAR each time that medication was given, to alert the nurses of the black box warning and what they were to monitor for. During an interview on 3/14/13 at 7:30 a.m. Administrative nurse A reported that the unit had no policy regarding black box warnings. The facility failed to identify and monitor the resident for the adverse side effects associated with the administration of medications with black box warnings.	F 329		